Nursing Facility Level of Care Determination
Questions & Answers

This Question & Answer document was developed in response to questions/comments received by the MDCH in response to the draft Nursing Facility Level of Care Determination policy (Project #0420-NF), and provides clarification to the final policy (issued October 1, 2004 as MSA 04-15). This infomation was orginally disseminated as part of the policy Consultation Summary dated October 7, 2004, that was sent to all persons commenting on the project.

INFORMED CHOICE PROCESS AND FREEDOM OF CHOICE FORM

Question: The consumer may be asked to sign the (Freedom of Choice) form and be admitted to the nursing facility before they may be aware of a Waiver slot.

Answer: The form is intended to confirm that necessary communication about functional/medical eligibility and program options has taken place. The conversation about these issues is not intended to occur solely at the time that the Freedom of Choice form is completed. Hospital discharge planners, community information and referral services, as well as nursing facility level of care providers, are expected to provide appropriate option information throughout the admission and enrollment process.

Question: This (Informed Choice Process) is inadequate to assure a true exploration of alternatives to placement. A single point of entry is required to independently offer long-term care choices and community options.

Answer: The Informed Choice Process, as identified in this policy, is intended to be a first step toward better community education about long term care options. This process only takes place at the time a consumer actually needs some level of long-term care support. Educational efforts to inform consumers of planning issues and local community options need to continue to be developed so that decision-making can be appropriate when crises occur. The Governor's Long-Term Care Task Force is exploring the issue of single point of entry.

Question: Can the care manager write up the informed choice form in the home and get it signed, then come into the office, get an official one printed, and attach it to the original document?

Does an extra visit to the home need to be made to get the applicant's signature on the Freedom of Choice form?

Answer: It is suggested that a blank form be carried to the beneficiary's home and completed there at the time of initial eligibility determination and perhaps assessment. The criteria for functional/medical eligibility are explicit; it is not necessary to rely on the electronic tool to determine an applicant eligible. A completed handwritten form is acceptable as long as the electronic tool is eventually completed.

Question: Freedom of Choice form, Field 104, community-based care, what is expected here? Can we refer to the Access Guidelines document for this information?

Will the state provide the NH with all of the brochures regarding MI Choice and PACE as per the Freedom of Choice?

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Will the community-based programs/care settings be responsible to provide the NH with their specific information regarding their care setting, or does the NH have to develop the master information list?

Answer: The essential information that must be provided to an applicant is that qualifying under the Michigan Medicaid Nursing Facility Level of Care Determination for one program makes the applicant eligible for all three programs, as long as they meet the individual financial eligibility requirements for that program. It is expected that the applicant be made aware of their eligibility, and guidance about where to find detailed information about these programs must be provided. It is not expected that the provider be expert in community options, but at least be able to refer persons to appropriate information and referral agencies in their area. The Access Guidelines in Attachment F were developed to help providers understand the public long-term care programs that might be available. In addition, MDCH will be publishing informed choice brochures in the next six months. However, providers are expected to have basic knowledge about the information and referral organizations in their communities.

Question: Will the state be providing the Freedom of Choice form? It is available on the Michigan Medicaid tool …however, will a blank form be provided to the NH for review?

Answer: MDCH will not be providing printed Freedom of Choice forms. Forms are available on the MDCH website or a blank form can be printed from the electronic web-based Michigan Medicaid Level of Care Determination at https://sso.state.mi.us.

Question: What is the time in which the Freedom of Choice form will be forwarded back to the facility so that the NH can inform the resident and their legal representative?

Answer: The Freedom of Choice form is not forwarded. The determination is made electronically when the Michigan Medicaid Nursing Facility Level of Care Determination has been completed in the web-based system. At that point, the Freedom of Choice form automatically comes into view and should be printed and completed. The provider must complete the Freedom of Choice form using a blank tool printed from the website.

Question: Is there a time frame that the NH has to inform the resident and/or their legally empowered representative of the outcome of the Freedom of Choice and corresponding determination of eligibility?

Answer: The provider must complete the Michigan Medicaid Nursing Facility Level of Care Determination process and Informed Choice process prior to admission to a nursing facility. If the facility does not plan to accept the applicant for nursing facility care, it does not have to complete the eligibility determination process.

Once the evaluation for functional/medical eligibility determination has been made, it is suggested that the provider inform the applicant immediately. The criteria for admission are explicit, and the provider should be able to identify whether the applicant does or does not meet the criteria. If an exception is requested, MDCH or its designee will inform the provider of the findings, in most cases immediately during business hours, or within three business days if a physician consultation

is requested. It is expected that the provider will notify the applicant immediately if during business hours.

Question: It is important that a witness not be required when completing the FOC form…it is difficult to obtain witnesses in situations where the client lives alone and may be isolated. This would create a real barrier.

Answer: It is not expected that a witness be obtained to complete the Freedom of Choice form when there is no one available. It is expected that family or others who have been chosen by the applicant as representatives be made aware of the options available. In those cases, consumer-appointed representatives also sign the form.

MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION

Question: Who determines eligibility? Will it be a non-health professional that bases eligibility on a score? Will they understand what community resources are available in different areas of the state?

Answer: For the time being, providers of the three programs that require the nursing facility level of care must determine functional/medical eligibility: the MI Choice Program, Program of All Inclusive Care for the Elderly, and Medicaid reimbursed nursing facility care.

Licensed personnel, such as an RN, LPN, social work BSN, MSN, or acting social worker with at least three years experience, must oversee the process for nursing facilities, although non-clinical staff may complete the evaluation. It is important that the person completing the form be well aware of Minimum Data Set (MDS) definitions.

The Family Independence Agency will continue to make financial eligibility determinations for Medicaid.

Providers are expected, at a minimum, to identify information and referral sources (i.e., the local Area Agency on Aging or Center for Independent Living) to assist persons in finding community based care.

Question: Safety risk – definitions of ADL performance do not include safety.

Answer: The definitions for ADL performance are based on the CMS definitions and do not include reasonable time issues or overall safety. The exception criteria, however, do address these issues so that the consumer at risk because of unsafe late-loss ADL performance should qualify.

Question: Is Field 6 of the tool the waiver agent or the care manager?

Answer: Field 6 is meant to identify the person who may be contacted about this case. In the case of the MI Choice Program, it may be the care manager.

Question: It is not clear if an applicant qualifies through one door, or points are accumulated through several doors. In order to capture the level of care needs for these populations, more than one

door would need to be considered. We believe that persons with dementia would be hard to assess.

Answer: It is only necessary to qualify through one door. In order to understand the care needs for a specific applicant, it is necessary to do a complete assessment. Each door represents the minimum functional status or characteristic in a given area to qualify for the nursing facility level of care. Persons with dementia can be difficult to assess; however, the doors should adequately address ADL performance, behavior, and safety/decision factors that most frequently impact persons with dementia.

Question: The physician requirement on the LOC tool is indicative of short- term care, not long-term care which is the focus for these policies.

Door 4 – these situations should only be identified if the conditions or treatments have a barrier to client abilities and needs. These conditions and/or treatments do not automatically affect one's self-care abilities.

I believe that using the MI Choice waiver to meet short-term needs is not targeting resources to those most in need of home-based community services. Often this group has sufficient help through Medicare services, as well as family members who are able to rally and assist for short periods of time. In addition, the process of applying for Medicaid itself does not lend itself to short-term enrollment. Often this is a complex, time-consuming process that participants may not wish to pursue in order to meet a short-term service need.

It is important to remember that while clients are usually motivated to leave a nursing facility because it means returning home, that same motivation will not be true for the MI Choice Program. In a substantial number of cases, disenrollment from MI Choice will mean loss of their Medicaid benefit.

As a care manger, it is very difficult to take away someone's Medicaid benefit. Care managers must have clear, written standards that spell out their justification for doing so. These written guidelines will also assist us when we are called into a hearing and appeals situation.

Answer: It is federally required that the nursing facility level of care definition include skilled care, which often is noted to be short-term. However, the applicant to the MI Choice Waiver must also require at least one Waiver service in order to be enrolled in the MI Choice Waiver. This requirement ensures that the applicant must require at least some functional support.

Those persons whose needs can be fulfilled using Medicare, or are not disposed to go through the Medicaid eligibility process for short-term needs, are not likely to access MI Choice services.

Question: The MDS definitions and Resource Utilization Groups (RUGs) scoring do not match the MDS-HC. The preadmission tool is not coordinated completely with the MDS based RUGs reports. A person could qualify under RUGs and not make it through the doors, and vice versa.

Definitions vary from 7 days to 14 days between the level of care determination and the MI Choice MDS form.

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A person on continuous oxygen will meet the eligibility criteria but not RUGs. So what do we do? Who will make the determination at that point and what is our liability with the look-back period?

The RUGs reports designed by CIM and UM for use by the Waiver agents to indicate functioning levels of individuals in the RUGs system no longer correlate with the draft level of care criteria. We will not have any scientific measurement tools to indicate an individual's level of functioning based on the RUGs system.

Answer: It is understood that the MDS definitions and RUGs scoring do not match the Michigan Medicaid Nursing Facility Level of Care Determination. The criteria were developed by UM to approximate the RUGs category of 'Physical A', using the MDS-RAI for nursing facilities.

An applicant will never qualify under the RUGs categories. The Michigan Medicaid Level of Care Determination is not designed to match the RUGs system. The RUGs system can continue to be used to characterize the overall service needs of the consumers, but eligibility must be determined using the new criteria. Some consideration may be given in the future to updating the MI Choice Program assessment tool to ensure a match with the determination form and the MDS-RAI.

The person who requires continuous oxygen AND at least one waiver service will meet the functional/medical criteria for enrollment. The RUGs category has no bearing on eligibility. The issue of the look-back period should not be a problem. Providers should use the look-back period to identify the characteristics of the applicant, as they are able.

Question: Therapy Category – define scheduled versus provided.

Answer: In order to qualify under Door 5, an applicant must have a continuing need for therapy and have received, or at least have scheduled, 45 minutes of therapy in the last week. Scheduled but not used minutes are included here since it is possible that the applicant may have been ill, or therapy unavailable and not delivered. The essential criteria are that the applicant has a continuing need for at least 45 minutes of therapy per week.

Question: "Wandering" – need a broader definition

Answer: The definition that is used is a (CMS) MDS definition. The wandering behavior is meant to include moving about without apparent purpose. Leaving the home and moving about the neighborhood are not required to be characterized as wandering.

Question: Behavior Category - Why are the weekly limits so high?

Answer: It is true that persons who qualify under Door 6 require incidents of a single untoward behavior at least four out of the last seven days. This is consistent with the RUGs definition for a 'Physical A' and is thought to work well, since in practice, persons tend to exhibit the same behaviors consistently. The Nursing Facility LOC Exception Process does address a lower threshold.

Question: Service Dependency Category - why do they have to demonstrate some service needs?

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Answer: MDCH understands that the consumer with lower levels of care needs who may have improved in functional ability may become service dependent and have difficulty adjusting to loss of program or care setting. Unless the consumer demonstrates some care needs, the impact of loss of program or care setting cannot justify the use of Medicaid funds to maintain the program or setting.

Question: Service dependency clause with only annual reviews could result in perpetual dependency. Recommend an end date to service dependency clause and strong requirements and enforcement of discharge planning, including adequate timelines, utilization of community resources (ensure application to public housing, vouchers, Meals on Wheels, Home Help, etc).

Answer: Service dependency only applies when a consumer has received services in a given program for one year, continues to have service needs, but does not meet other Michigan Medicaid Nursing Facility Level of Care Determination criteria. Ongoing discharge planning and search for an appropriate community resource is always required. There will always be persons who will 'hover' around the level of the bar, and who continue to be at risk for institutionalization.

Question: There is no consideration of the ability or presence of a caregiver. If a person requires 24-hour supervision, who will provide care if the person is rejected? There are insufficient programs to meet the needs of those who previously would have been admitted. There is concern for older adults who could fall into a service gap, should adequate community services not exist.

Answer: This policy was designed to identify the person at risk who may have or may not have a caregiver. The ADL Performance Door, the Cognition Door, and the Behavior Door were all developed with the idea of defining the person at risk when left alone. Anyone who truly requires 24-hour supervision care should meet the criteria for enrollment/admission. The policy itself does not address service gaps in the community, but is only designed as a starting point in rebalancing and identifies those at high risk who need public services.

Question: Guidelines list health professionals who may complete the tool – what about nurse practitioners?

Answer: Nurse practitioners are licensed nurses and may complete the tool.

Question: Increased staff time due to using two separate forms. Nice to tie it into the current MI Choice/MDS system so staff complete only one form.

It is inefficient to require both the MDS and the tool to be used. The entry process is duplicated for two different tools. Why not utilize the RUGs report as verification of eligibility?

Answer: There is no mandate as to the format for written versions of the MDS-Home Care or the criteria. If desired, agents are free to incorporate the criteria into the hard copy assessment tool and not repeat questions. Separate data entry would still be required; however, since most participants will enter through Door 1, it is not expected to be overly time consuming.

Analysis of the MDS-Home Care and the MDS-Resident Assessment Instrument for assessment at admission and along the course of stay was considered as a method to identify adherence to the criteria. However, the MDCH administration decided that an 'up front' system was appropriate to

confirm prior to admission that an applicant meets the criteria, rather than waiting for submission of the MDS after admission.

EXCEPTION PROCESS

Question: It is not clear how many elements are needed to trigger an exception.

Answer: Only one element is required to trigger an exception.

Question: Exceptions- can persons appeal and request an exception at the same time?

Answer: Yes; in fact, it is suggested that persons appeal and request an exception at the same time so that the appeal process can be initiated when indicated.

TELEPHONE INTAKE GUIDELINES

Question: Telephone Intake Guidelines - Is this the tool to be used when a nursing home is going to initiate a level of care exception process?

Answer: The Telephone Intake Guidelines are meant to help providers identify persons over the telephone who might be appropriate for the nursing facility level of care. It may be used to screen persons for further evaluation. The Telephone Intake Guidelines are not part of the exception process.

Question: Tool does not screen enough out. Costs and time involved.

Answer: The Telephone Intake Guidelines have been revised to better meet the MI Choice Program screening needs.

Question: If the phone screen is not required to be used by a MI Choice agent, how will an agency determine a potential participant…how will callers be identified?

Answer: Providers are not constrained in the telephone communications that must occur with consumers in terms of all the questions that they may ask. What must happen, however, is that if they choose to use a consistent tool to identify persons who are most likely to require nursing facility level of care services, they cannot use the prior telephone screening mechanism since it is based on a different system and level of care criteria.

Question: Should add identification of client ability to bathe, perform personal hygiene, and ambulate (in the telephone screen).

Answer: While this information may be pertinent to other program eligibility, it is not pertinent to eligibility for the three programs covered by this policy. Providers may ask about these areas if they choose, but they are not elements of the Telephone Intake Guidelines.

Question: Will there be any MI Choice reimbursement for assessments done for persons not eligible for nursing facility level of care services?

Answer: MDCH does not reimburse specifically for assessments, but includes that work in the administrative rate for the MI Choice Program.

NURSING FACILITY TRANSITION AND DISCHARGES TO THE COMMUNITY

Question: Several respondents expressed concern about the discharge options for residents in nursing facilities who will not meet level of care criteria and the inadequacy of the involuntary discharge process. They were especially concerned about payment during the discharge process.

Answer: MDCH expects there to be few circumstances where a resident has been admitted into a nursing facility, but later does not meet level of care and refuses to leave the facility. Discharge planning should begin at admission for all residents and especially those who enter for rehabilitation or short-term illness and expect to return to their home. In order to facilitate discharge planning, facility social work staff will have to be very knowledgeable about a variety of community resources, perhaps on a much broader and deeper scale than they do now.

When a resident improves and no longer meets the Michigan Medicaid Nursing Facility Level of Care Determination requirements, an adverse action notice should be issued when the discharge plan and restorative nursing plan have been met or activities have stalled. The required content for adverse action notices is still under development and will be available on the MDCH website at www.michigan.gov/MDCH by November 1, 2004.

When issued an adverse action notice, the resident has several appeal options. The resident may request an immediate review as identified in the policy or may appeal the level of care determination directly to MDCH through its Administrative Tribunal.

When the hearing decision is that the resident does not meet LOC criteria, and the resident refuses to consider a discharge plan, the facility must initiate the Nursing Facility (NF) Transition Process. It is strongly suggested that this process be initiated prior to consideration of involuntary discharge.

The NF Transition Process is initiated upon contacting MDCH with information about a consumer when no realistic community placement options have been identified or the consumer refuses all attempts at community placement. The contact person for NF Transition Process is Mary Gear, who can be contacted at 517-335-5827 or at GearMar@michigan.gov.

The NF Transition Team at MDCH, which will include representatives from MDCH long term care policy, mental health, and housing areas; the Family Independence Agency; and the Office of Services to the Aging will meet with the provider to review realistic options for the resident. MDCH will continue to provide Medicaid funding for nursing facility care through this process and when no realistic community options have been identified by the Team. Should community options not be available for the resident, MDCH will continue reimbursement until an appropriate discharge is arranged.

When the NF Transition Team determines that reasonable options have been provided to the resident, the Team may suggest that the provider initiate the involuntary discharge process. The resident again has the option to appeal the involuntary discharge notice. If the hearing decision is

that the resident does not need nursing facility care, and reasonable community options are still available, then the resident must leave the facility. Medicaid will continue payment throughout the involuntary discharge process and appeal.

The facility's obligation throughout this entire process is to help the resident explore and understand their placement options.

If the resident appeals at any level, Medicaid will continue to pay until the appeals are exhausted, reasonable community options are available, and a final NF Transition Team decision is reached.

SPECIFIC RESTORATIVE NURSING PLANS AND DISCHARGE PLANNING

Question: Restorative care is confusing; please delineate it from skilled care. Does this refer to MI Choice also?

These issues usually fall under a home health agency and care managers don't get involved in this much detail. Will it be sufficient to document on the care plan that skilled nursing or therapies will address these issues? Will there be training on the restorative nursing piece if providers are held to this in the waiver?

Answer: Yes, restorative care criteria apply to the MI Choice Program also. Care planning for the consumer must include individualized rehabilitation goals when indicated. When skilled nursing or rehabilitative therapies are involved, their care plans may well address these goals. However, it is required that rehabilitation goals and maintenance of function issues be documented within the MI Choice Program care plan on an ongoing basis with specific interventions, such as doing as much of their personal care as possible (specified), avoid treating arthritis pain only with sitting in a chair, etc. Refer to the Process Guidelines for a more thorough understanding of restorative nursing care. MDCH will consider training on restorative nursing care later if necessary.

Question: There is a need for clear written guidelines on how to determine if someone continues to meet criteria once they are in the program. As indicated in the document, applicants who qualify through doors 3, 4, or 5 will often have short-term support needs. We will be required to have a restorative plan of care in place for these applicants. However, the document provides no clear written guidelines as to how we determine when a client has fulfilled that restorative plan of care and no longer meets the nursing home level of care criteria.

Answer: It is not possible for MDCH to identify how a provider is to determine when a client has fulfilled their restorative care plan. The care plan itself must identify the restorative goals for each participant and barriers to achieving them. When those goals have been met, or the participant has achieved optimal functional ability and has no further potential to improve, the restorative care plan is met. It is important, though, to help the consumer identify those activities that will assist them to maintain their current functional level. At the point when the restorative goals have been met, if the participant does not meet the Michigan Medicaid Nursing Facility Level of Care criteria (including Door 7) or through the LOC exception process, it is appropriate to expedite discharge. However, it is imperative in this situation to start discharge planning from day one.

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ACCESS GUIDELINES

Question: Section 2.15a fails to include palliative care and symptom management beyond pain within the description of hospice services. The description also fails to mention many required elements of hospice programs, such as bereavement services and respite care.

Section 2.15c states interim services are provided while awaiting eligibility determination. A caseworker will be assigned at the beginning of the application process. The statement does not describe how interim services are provided or who acts as the caseworker.

Answer: Section 2.15a of the Access Guidelines is intended to give a brief overview of hospice services, not the complete array of options. The language has been modified to be more informative.

In Section 2.15c of the Access Guidelines, the interim services are provided by the hospice. The caseworker is the FIA eligibility worker. Language has been modified to make this clearer.

APPEALS

Question: If an individual is determined to be not eligible for services and notice is given to the person who then appeals that decision – during the appeal, will Medicaid continue to pay for services? Or is the beneficiary liable? The person most likely has no means to pay for the services so the facility would be liable to provide uncompensated care.

Answer: Medicaid will continue to pay for services as long as the participant appeals within the required time frame.

Question: Immediate review – adverse action notices. What happens if this occurs on the weekend or on the holiday? Will Medicaid continue to pay until the review is completed?

Answer: Yes, as long as the participant requests the appeal by noon of the next business day. Medicaid will reimburse at a minimum through the date of the immediate review decision and during the appeal process.

Question: The program states under immediate review – adverse action that a beneficiary may request, before noon of the first working day after the date of receipt of the notice, that MDCH or its designee will review the case. This will certainly involve additional personnel at the state level – an additional cost of the program.

This section further states that MDCH will notify provider of the determination by the first full working day after the receipt of the beneficiary request and the required medical records are received. Given the potential volume from Michigan nursing homes, this time frame is unrealistic.

Answer: MDCH does not expect a large volume of appeals from nursing homes. Only 7-8% of current residents would not meet the criteria if MDCH applied it across the program today. In addition, the appeals will be handled by a vendor with experience in both telephonic review and appeals of non-coverage.

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Question: Is there a timeframe that the nursing home has to issue the adverse action notice?

Answer: The nursing facility must issue the adverse action notice immediately when the level of care determination indicates that the applicant does not meet the requirements and an exception is not being requested.

For continuing stay participants, the nursing facility must issue the notice when the participant no longer meets the level of care requirements, restorative nursing goals have been met, or the participant has no further potential to improve. The notice should reference discharge plans when indicated. Please refer to the above discussion regarding Nursing Facility Transition Process and Involuntary Discharge.

GENERAL ISSUES

Question: Many issues which affect the more rural communities (transportation, accessibility) do not seem to be addressed. The policy seems to be more urban-oriented. It does not seem to clarify pre-screening, when, who, how? It proposes guidelines, but does not clarify resources to assist agencies in meeting requirements.

Concerned about the negative effects the proposal as written will have on our older populations. The proposal does not:

- Address the realistic needs of our rural residents. A significant percent live alone, in isolated areas, are age 80-90 plus, cared for by a frail, chronically ill spouse or aging adult child.
- Consider the lack of availability of MA community-based rural services. Few adult foster homes accept Medicaid; only two assisted living facilities are located in our service area, and are beyond the financial means of MA clients; the PACE program may not be cost effective in our rural, sparsely populated area; the MI Choice Program slots are limited and filled to capacity.
- Recognize the financial implications for residents of our area, or the providers of services. The tax base is limited; the major industry is tourism; public transportation is limited, if available; provider funding sources have been shrinking for some time; additional funding sources, state and federal, are limited.
- Promote and encourage continuity of care, and planning and coordination among health care providers. All providers, nursing facilities, home care agencies, hospitals, commissions/councils on aging, assisted living facilities are being subjected to increasingly restrictive and incongruent legislation.
- Address specific key areas which are not fully developed in the proposal: definition of provider, case manager, role of each provider, timeframes to complete each phase of the process, contacts at the state level, to name a few.

- Realistically assess the ability of FIA and CMH services and their ability to meet the needs of our older populations in northern lower Michigan. FIA uses primarily unskilled family or paid workers who are not supervised by professional health care staff. CMH provides only office, not home-based, services.

- Identify key providers of services to the older population in northern lower Michigan that have been left out of the loop, namely local health departments, local commissions/councils on aging, and certified home health and hospice agencies.

Answer: This policy revises the functional/medical eligibility criteria for the three nursing facility level of care programs under Medicaid: the MI Choice Program, Medicaid reimbursed nursing facility care, and the PACE Program in Detroit. It does not address the systemic issues of Medicaid Long Term Care in Michigan.

While the policy does limit the number of consumers who will be eligible for nursing facility level of care programs, its overall impact in terms of numbers is relatively small. Only 7-8% of nursing facility residents may not be eligible, and those who have been in the program for at least one year may become eligible under Door 7. A larger percentage of MI Choice Waiver participants (projected to be over 30%) may be impacted. However, the overall number of impacted participants in MI Choice across the state will be small, especially considering Door 7.

At most, the policy impacts those in the future who have some needs but really do not require the level of services requiring a nursing facility. It is true that community options continue to be limited in many areas. This policy does not alter that situation. However, there are many other MDCH initiatives that work to address some of these issues, i.e., the Governor's Long Term Task Force and numerous grants that work to increase the community options for long term care participants.

When providers and care managers are discussed in the policy, those terms refer to the roles associated with the three Medicaid reimbursed programs that must utilize the nursing facility level of care definition: nursing facility care, the MI Choice Program, and PACE.

Question: Eligibility requirements only apply to Medicaid beneficiaries and to people already in the system at the point they apply for Medicaid benefits. The screening tool must be done with every person admitted at time of admission. This would assist persons to plan for long term care services. Some may choose to move elsewhere.

Answer: MDCH has developed this policy to address the issue of consistent tool use for nursing facility level of care eligibility across the required three programs. Issues about the entire Michigan Long Term Care System are not meant to be addressed here. While education, planning, and some gate keeping toward the higher levels of care are important, there are other state and community groups working on these issues.

Question: The tool will result in higher acuity of MI Choice participants, requiring the current waiver caps to be raised.

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Serving a higher acuity client and dropping the "Physical As" will require an increase in the cost per day from $32 to $42, per analysis provided by UM. Raising the service rate by a couple of dollars will not cover the services expenditures of this population.

Answer: There is a plan to increase the current maximum average reimbursement for the MI Choice Program. For 2005, it is expected to increase $2.00; however, it is projected to increase for the following two fiscal years based on the attrition rate of the lower acuity population until it meets the average cost per participant day of the current participants who are noted to be at higher acuity than a 'Physical A'.

Question: Will all clients require a quarterly assessment?

Answer: This policy does not affect what the current assessment requirements are for each individual program. Assessments are required for each program/setting and participant situation.

Question: Does the policy allow for retroactive eligibility for Medicaid prior to the application file date at FIA? Will the current practice of presumptive eligibility continue?

Answer: Yes, the policy does not affect the presumptive eligibility practice or retroactive eligibility. In addition, the electronic tool allows up to 90 days of care prior to completion of the tool when a beneficiary has been determined eligible retroactively.

Question: Is the annual re-certification the same as the current 4th quarter assessment?

Answer: Annual re-certifications for eligibility are currently required in all three programs. The policy does not change this process. The annual re-certification date often falls on the anniversary of the admission date. MDCH has changed the requirement for continuing stay participants to the following: current participants on the implementation date must undergo the level of care evaluation no later than the next annual MDS date or annual re-certification date. All current participants must be evaluated within one year of the implementation date.

Question: How do we ensure that the client remains eligible? What process will we use?

Answer: Providers, nursing facilities and MI Choice Program care managers are expected to understand the criteria overall. As they reassess participants on a quarterly basis, they should be identifying changes in condition and note any improvements that may make the participant not eligible in regard to functional/medical eligibility.

Status updates based on the care plan should specifically identify any improvements in function, especially for those who are anticipated to require only short-term care.

Question: Need administrative law created to support the new criteria and decisions that agencies will have to make. Otherwise, the ALJs will have a field day.

Answer: Administrative law is not needed as such, but decisions are based on federal and state law and MDCH policies.

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MDCH anticipates that the policy will bring some clarity to the issue of functional/medical eligibility. The Administrative Tribunal has reviewed the policy.

Question: Will there be enough time to train and set up policies, procedures, processes, and computer systems?

When will the state be providing educational workshops for the NH? If implementation is October 1, time is short.

Answer: MDCH will implement the new criteria and processes on November 1, 2004. Providers should plan to implement as of this date, and begin work on new policies as soon as possible.

Regional trainings were scheduled for late August and September. An invitation was issued to hospitals, nursing facility providers, MI Choice Waiver Agents, hospice providers, and other parties.

The training was videotaped, and providers or organizations may borrow a tape for further staff training in their facility. In addition, you may request an onsite training if you have sufficient numbers of attendees to warrant it. To arrange additional training, please contact Deanna Mitchell at 517-241-8265 or MitchellDeanna@michigan.gov.

Question: Physician signature is still required. Is this really needed….are physicians going to be able to bill for their time? Vendors still have to obtain separate orders for care that legally requires a physician order. Can we get a verbal order and a written order as follow up?

Answer: In a nursing facility, a physician's order is a federal requirement and must be obtained. This is not a new requirement.

MDCH has eliminated the physician signature requirement for enrollment into the MI Choice Program.

Question: Requiring licensed social work staff will drive the cost of case management up for the MI Choice Program. Staff with background and education in social work have proven to have the competency and skills necessary to service clients. No provision to grandfather staff.

Answer: The requirements for care management have not changed. Persons who meet the current requirements for care management may perform the eligibility evaluation. In nursing facilities, trained non-clinical staff may perform the evaluation with oversight from clinical staff.

Question: Will the LOC determination be completed at the same time the assessment is done? If the LOC determination is completed by a social worker and not done at the time of the assessment, then a nurse will be required to return and assess the participant. The method of the admission process is unclear.

Answer: It is MDCH's suggestion that providers be prepared to complete the initial assessment for the MI Choice Program at the same time of the evaluation for functional/medical eligibility.

Nursing Facility Level of Care Determination
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Question: Will clients with community Medicaid only need verification of eligibility at time of enrollment (current practice)?

Answer: Yes, the policy does not change this practice.

Question: Retrospective review and Medicaid recovery does not mention the retrospective review is to be completed by the MDCH designee. Was this an oversight?

Answer: It is planned that retrospective review be performed by an independent vendor, and a request for proposals has been issued that includes this work, along with other utilization work, currently contracted out by MDCH. Medicaid recovery, when appropriate, will be performed by MDCH.

Question: Policy states that the screen should be done along with annual re-certification. Some examples of what this date is would be helpful. Discussion about this date has stated it could be coordinated with the PASARR but not all the time; please provide examples or clarification.

Answer: The criteria must be applied to those participants who are receiving services as of November 1, 2004 under one of the affected programs. The criteria should be applied no later than the annual re-certification date or the next annual MDS date, but must be completed prior to November 1, 2005. Federal law requires that programs re-evaluate the participant for eligibility annually. FIA must reassess financial eligibility annually, and that date is the date of the annual re-certification. It is suggested that this coincide with the annual PASARR reassessment, but it is not required.

Question: Admission requirements (for nursing facilities) state that the information must be provided both orally and in a written language that the beneficiary understands. Will this be an allowable base cost for Medicaid reimbursement? Page 6 goes on to asterisk items that copies must be provided. Will the MDCH have these documents available in the appropriate languages?

Answer: This requirement for information to residents at admission is not new and has been part of Medicaid policy for many years. MDCH provides some written material, but most of the requirements have to do with the policies and procedures of the facility and, therefore, are the responsibility of the facility. Medicaid expectations for fulfilling this requirement are unchanged. If a translator or interpreter were needed, it would be the facility's responsibility to find one, pay for the service, and claim it on their Medicaid cost report for Medicaid beneficiaries.

Question: Policy states that a facility must notify residents of any changes to the information (under Admission Requirements in Section 4.3 of the Nursing Facilities Coverages and Limitations Chapter). When or how often should this be done, for example, for every change or at the re-certification time?

Answer: This is not a new requirement. Medicaid expects that residents will be notified when there is a significant change in the facility's policies or protocols.

Question: The lack of professional accountability following the completion of an adverse action notice. Does our professional responsibility end after we have provided information to an applicant? Who advocates for an applicant? Is anyone responsible to determine if an individual has contacted the resources provided?

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Answer: Unless there appears to be an issue of competency for an individual, it is assumed that the person will act in his/her own best self-interest. Referral to a local area agency on aging or center for independent living is an appropriate response for resource information. For issues where competency would appear to be a concern, a referral to Adult Protective Services through the Family Independency Agency would be required.

The informed choice process is not meant to address all the long term care information needs, but to direct persons where to get pertinent information about alternative settings.

Question: There needs to be coordination and planning of care across the continuum. Discharge planners in acute care facilities initiate multiple calls to nursing facilities seeking placement to meet their mandate of quick discharge. That means several different facilities will conduct assessments and submit information to determine eligibility. Duplication will be inherent in the process unless all providers of health services are included in a discussion of the proposal. Perhaps it is an opportunity for all health care providers to work together and improve access to health care at all levels.

Answer: Nursing facility providers may perform a criteria review of potential residents, but should enter data in the system only if there is a serious possibility that they will admit the resident. Data should not be entered into the system every time a hospital calls regarding bed availability or asks about a potential admission. In addition, hospital discharge planners have access to the criteria and should understand the potential resident's needs.

Question: Who would administer a retrospective determination? When would this be done? How is this determination initiated? Who will be monitoring this?

Answer: Retrospective reviews will be performed by MDCH or a designee as part of its audit function. MDCH will initiate the review and will monitor facility and program responses.

Question: Communicate with local discharge planners who are unaware of the changes and implications for their mandate to discharge quickly.

Answer: The policy has been disseminated to all hospital providers in the state. In addition, hospital discharge planners were invited to the regional trainings held in late August and September. Since most admissions from hospitals to nursing facilities are covered under Medicare, the policy is not expected to impact their processes overall.

Question: Each of the public agencies discussed in the Access Guidelines will share information regarding a person with other agencies or organizations if the person or legal guardian has signed a release of information form. Can this be included in the NH notice of Privacy Practices/HIPAA?

Answer: HIPAA requirements apply here. Information may be shared if the resident or responsible party signs a release. The provider determines what the release will look like.

Question: Is it the eventual plan of the state of Michigan that there will be an associated dollar amount attached to each door, with the amount of reimbursement from Medicaid to provide care for each

specific resident contingent on the qualifying door. This will be much the same concept as the RUG determination under Medicare.

Answer: No. The underlying entry system is based on a minimum expectation of function within six categories and service dependency. The Door system does not adequately include all of the characteristics necessary to describe the amount of care required by each participant. A case mix system will be evaluated by MDCH in the next 24 months, and the RUGs system base is proposed.

Question: How will the system be monitored?

Answer: The data from the MDS-Resident Assessment Instrument and the MDS-Home Care will be analyzed on a routine basis and specific cases will be identified for auditing. A vendor will audit the cases for nursing facilities. MDCH MI Choice Program and PACE Program staff will do onsite reviews to monitor those programs.

Question: Will the state surveyors be educated to be the watchdog for the accuracy of the application of criteria?

Answer: No, the survey agency is not a watchdog for level of care criteria. However, survey staff are aware of the level of care criteria and will continue to monitor discharge planning requirements as part of their usual monitoring.

In September 2004, MDCH extended the MPRO contract to perform the exception reviews and audit nursing facility medical records for eligibility and data accuracy. MDCH Waiver program staff will monitor their program, and MDCH PACE staff will monitor the PACE site.

Question: This is apparently a web-based system that will automatically analyze the information, make the determination, and result in the Freedom of Choice form. How can the nursing homes begin to assess the impact that this will have on our facilities without access to the web program ahead of time. Either make the web program available for trial entries or give the nursing homes the door criteria for resident eligibility.

Answer: The nursing homes currently have the criteria in the form of the hard copy tool. Scoring in any Door will permit entry into the facility under Medicaid. The scoring criteria are included at the end of each section and states what is needed to "meet the nursing facility level of care".

Question: If the requirements for the content of a resident care plan (as required in Attachment C) of this particular program are not met, will this also be a citable finding by the state surveyors?

Answer: The content requirements for the resident care plan are consistent with the current federal requirements for individualizing care and discharge planning. Surveyors already have the ability to cite for these issues if indicated.

However, it is not the Nursing Facility Surveyor's responsibility to oversee Medicaid policy implementation in this instance. Retrospective review will be performed by an independent entity.

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Question: The tool continues to evidence a program with considerable costs associated both for the State of Michigan as well as for the nursing homes. Should it be determined that the implementation of the process is a given, there are many areas that need to be clarified and education needs to be provided to the nursing homes and whomever the persons are that are going to be the monitors/surveyors of the system.

Answer: The policy promulgation process has included input from many different community sources. The public comment period is one of the latter steps to help in identification of areas for clarification. All input is appreciated. The monitors for this program will be a specific vendor and/or MDCH staff familiar with both the policy and the individual programs being evaluated. In addition, there were regional provider and stakeholder trainings based on the final policy.

Question: The State of Michigan needs to likewise inform the public of the tool and the ramifications to persons on Medicaid, specifically the indigent elderly.

One would like to believe that the goal of the program is to ensure appropriate care and corresponding facility placement for the ill, indigent elderly. However, given the timeliness of the program, primary motivation would appear to be a monetary issue. At a time when our state is in a strained economic situation, this program will be an unnecessary cost to the state as well as the facilities.

Answer: The goals for the changes are multiple. It is necessary to identify those persons who require a level of care that necessitates a high number of resources as defined by the nursing facility level of care. This policy assists in providing those high level services to those who need them, and makes each of the affected programs use the same tools to make utilization decisions. These initial changes will hopefully set the stage for movement to single point of entry programs. The amount of any potential savings is minimal compared to the $1.2 billion Medicaid expenditures for NF care setting. The cost of implementing this program for the state has been relatively small.

Question: It could most certainly be anticipated that the residents of the state will be outraged at the ramifications to their loved ones. Rural communities especially do not have alternative health care settings readily available and willing to accommodate a person with only Medicaid as their primary payer for care.

Answer: It is anticipated that the number of current residents that may be affected is very small and that, overall, the number of persons affected in the future is quite small. It is true that community options for long term care are limited, but this policy does not affect that situation.

The Governor's Long-Term Care Task Force is currently addressing community long-term care options.

Question: The aims of the bulletin cannot be realized without corresponding change to funding streams for long-term care. Concern is raised that screening to assess appropriate care needs will have little value to Michigan's Medicaid recipients if resources are not available to provide a continuum of services.

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Answer: This policy is not meant to address issues regarding service gaps in the community for Medicaid long-term care. It is meant as a starting point to ensure that those persons with the highest care needs are cared for in the more intensive programs and settings. While MDCH understands that there are continuity and access issues for long term care participants, those issues are being addressed in the Governor's Long-Term Care Task Force.

Question: No mention of health plans…if our health plans do not use the same criteria for their admissions, after the 45-day obligation, will the beneficiary have to be re-evaluated for admission? Or would the admission remain in place?

Answer: All persons who need rehabilitative services through the health plans will qualify for the nursing facility level of care. However, they may not meet the requirements after rehabilitation is complete. The beneficiary will have to be evaluated for functional/medical eligibility when Medicaid FFS coverage is anticipated whether or not the rehabilitation is complete.

If rehabilitation is complete before the end of 45 days, the health plan will have to discuss with the nursing facility the discharge plan for a given resident. If the resident meets the functional/medical criteria and chooses the nursing facility setting, then the provider may admit the person after the electronic tool has been completed.

If rehabilitation is not complete before the end of 45 days, the resident will continue to meet the functional/medical eligibility requirements; however, the electronic tool must still be completed prior to providing any services payable under Medicaid Fee for Service. If the resident has no other nursing facility level of care needs other than rehabilitation, the provider will have to initiate a discharge plan as soon as possible.